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Update: Investigation of Bioterrorism-Related Inhalational Anthrax — Connecticut, 2001

Since October 3, 2001, CDC and state and local public health authorities have been investigating cases of bioterrorism-related anthrax (*1–5*). As of November 28, a total of 23 cases have been identified; 11 were confirmed as inhalational anthrax, and 12 (seven confirmed and five suspected) were cutaneous. Epidemiologic investigations to identify the source of exposure to *Bacillus anthracis* continue for a case of inhalational anthrax in a hospital stockroom worker in New York City (NYC) and, most recently, a case of inhalational anthrax in an elderly woman in Connecticut (CT). Antimicrobial prophylaxis is continuing in persons exposed to *B. anthracis*, and surveillance to detect new cases of bioterrorism-related anthrax is ongoing. This report summarizes the findings of the case investigation in CT.

On November 16, a 94-year-old woman who resided in Oxford, CT (2000 population: 9821), presented to a local hospital with fever, cough, weakness, and muscle aches of approximately 3 days' duration. She had no history of chills, headache, rhinorrhea, vomiting, diarrhea, or abdominal or chest pain. She had a medical history of chronic obstructive pulmonary disease, hypertension, and renal insufficiency. On admission, the patient had a temperature of 102.3 F (39.1 C) with an elevated heart rate and room air oxygen saturation of 93%. Physical examination was otherwise unremarkable. Initial chest radiograph had no evidence of pulmonary infiltrate, pleural effusion, or widened mediastinum. Her white blood cell count was 8,100 cells/mm^3 (78% neutrophils, 15% lymphocytes). Hematocrit, platelet count, and electrolytes were normal. Blood and urine cultures were obtained and the patient was admitted for dehydration and possible urinary tract infection.

On November 17, gram positive rods were noted on microscopic evaluation of the blood culture and gram negative rods were isolated from the urine. Antibiotic therapy was initiated for possible sepsis with vancomycin and ceftazidime, and changed to ampicillin/sulbactam and oral ciprofloxicin later that day. On November 18, the patient had progressive respiratory distress and confusion. Repeat chest radiograph revealed a left-sided pleural effusion and possible infiltrate but no mediastinal widening. A chest CT was not performed. Thoracentesis performed the following day obtained 800 ml of serosanguinous fluid with 4,224 red blood cells and 1,463 white blood cells. On November 19, the patient was transferred to the intensive care unit and required mechanical ventilation and vasopressor support. Clindamycin was added to her antibiotic regimen, and ciprofloxicin was changed to intravenous administration. The patient's condition deteriorated, and she died on November 21.

Bioterrorism-Related Inhalational Anthrax — Continued

On November 19, the Connecticut Department of Public Health (CDPH) was notified by the hospital of the positive blood culture results. On November 20, the isolate was identified as *B. anthracis* at the CDPH laboratory with confirmation at CDC the following day. The *B. anthracis* isolate was indistinguishable by molecular typing and antibiotic susceptibility patterns when compared with the strain from recently identified cases of bioterrorism-related anthrax. An autopsy revealed hemorrhagic mediastinal lymphadenitis with positive immunohistochemical staining for *B. anthracis* on spleen and mediastinal lymph node tissue.

The patient lived alone in a rural area of CT and was home-bound except when provided transportation by friends and family. Interviews with family members and others were conducted to construct a time line of the patient's activities during the 60-day period preceding her illness. The time line was used to guide environmental sample collection. As of November 27, none of the environmental samples from the patient's home, local businesses, and other areas that she frequented has yielded *B. anthracis*. In addition, nasal swabs from friends and relatives who may have had common exposures with the patient were negative for *B. anthracis*. These persons were started on ciprofloxicin or doxycycline for postexposure prophylaxis. The decision whether or not a full 60-day course is necessary will be made after further investigation into the potential source of exposure.

On November 20, environmental testing was conducted at the local post office and regional mail distribution facility involved in delivery of the patient's mail. In addition, sampling was performed on mail recovered from the patient's home, area mailboxes, and the mail carrier vehicle. As of November 27, none of the samples have yielded *B. anthracis*. Nasal swabs also were taken from 460 postal employees in the two facilities; all are negative for *B. anthracis*. Mail flow investigations have identified several letters that were delivered to the area serviced by the patient's local post office and that had previously passed through the mail facility in Trenton, NJ, shortly after the *B. anthracis* contaminated letters addressed to two U.S. Senators. However, no such letters are known to have been received by this patient. On November 21, approximately 900 postal employees at two facilities in CT were started on either ciprofloxicin or doxycycline, pending the results of further investigation.

Surveillance for new and possibly undiagnosed anthrax cases is being intensified by contacting hospitals, laboratories, physicians, and by reviewing death certificates. Environmental and case investigations to identify a source of *B. anthracis* exposure are ongoing.

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Editorial Note: The source of exposure to *B. anthracis* for the 94-year-old CT resident remains unknown. The genetic characteristics of *B. anthracis* isolated from this patient links this case with the previous bioterrorism-related cases of anthrax. However, this patient differed from most previously identified cases in both epidemiologic characteristics and potential sources of exposure. The patient in CT had limited activity outside her home, had not visited a media company or postal facility, and had an onset of symptoms at least 3 weeks later than previously reported patients. In addition, one notable clinical finding was the absence of a pulmonary infiltrate, pleural effusion, or mediastinal widening on the admission chest radiograph.

Bioterrorism-Related Inhalational Anthrax — Continued

Epidemiologic findings indicate that recent cases of inhalational anthrax most likely occurred from aerosols generated from opening a letter containing *B. anthracis* powder or from aerosols generated in processing a sealed letter containing *B. anthracis* powder at a postal facility. The most recent case in CT and a case of inhalational anthrax in the 61-year-old hospital stockroom worker in NYC did not have either exposure identified. Possible sources of *B. anthracis* under investigation include exposures inside and outside the home and mail that passed through contaminated mail facilities. The investigation by public health and law enforcement authorities to find the source of exposure continues and surveillance for new cases of bioterrorism-related anthrax is ongoing.

Clinicians and laboratorians should remain alert for symptoms or findings that might indicate anthrax (*6*). Information on anthrax is available at <http://www.bt.cdc.gov>.

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Update: Adverse Events Associated with Anthrax Prophylaxis Among Postal Employees — New Jersey, New York City, and the District of Columbia Metropolitan Area, 2001

Antimicrobial prophylaxis to prevent inhalational anthrax has been recommended for persons potentially exposed to *Bacillus anthracis* as a result of the recent bioterrorist attacks (*1*). During October 26–November 6, 2001, an epidemiologic evaluation to detect adverse events associated with antimicrobial prophylaxis was conducted among 8,424 postal employees who had been offered antimicrobial prophylaxis for 60 days in New Jersey (NJ), New York City (NYC), and one postal facility in the District of Columbia (DC). This report summarizes preliminary results of that evaluation, which found that few employees receiving antimicrobial prophylaxis sought medical attention for symptoms that may have been associated with anaphylaxis. Persons with exposures to *B. anthracis* related to the bioterrorist attacks should complete the full 60-day course of antimicrobial prophylaxis.

In NJ, NYC, and DC, a questionnaire was administered on days 7 to 10 after postal employees received prophylaxis (when they returned for medication refills). In NYC and DC, the questionnaire was self-administered by postal employees; in NJ, nurses interviewed postal workers and administered the questionnaire. Information was collected about the type of antimicrobial used, the occurrence of adverse events, medical attention sought for adverse events related to antimicrobial prophylaxis, and discontinuation of prophylaxis. Persons who reported hospitalization or sought medical attention for symptoms that may have been associated with anaphylaxis (i.e., difficulty breathing;

Adverse Events — Continued

throat tightness and difficulty swallowing; swelling of lips, tongue, or face; and rash, hives, and itchy skin) are being followed up closely by contacting patients and clinicians to confirm or exclude possible hospitalizations and life-threatening adverse events.

Of the 8,424 postal employees offered antimicrobial prophylaxis, 5,819 (69%) completed or were administered the questionnaire to evaluate the occurrence of adverse events. A total of 3,863 (66%) had initiated antimicrobial prophylaxis*; of these, 3,428 (89%) reported using ciprofloxacin for antimicrobial prophylaxis; 435 (11%) used other antimicrobials (when ciprofloxacin was contraindicated), including doxycycline (6%) and amoxicillin (1%) (Table 1). Of the 3,428 persons on ciprofloxacin, 666 (19%) reported severe nausea, vomiting, diarrhea, or abdominal pain; 484 (14%) reported fainting, light-headedness, or dizziness; 250 (7%) reported heartburn or acid reflux; and 216 (6%) reported rashes, hives, or itchy skin. Of those persons taking ciprofloxacin, 287 (8%) discontinued the medication; 116 (3%) discontinued the medication because of adverse events, 27 (1%) discontinued because of fear of possible adverse events, and 28 (1%) stopped taking the drug because they "did not think it was needed." For the 3,863 persons on any medication for antimicrobial prophylaxis, 83 (2%) sought medical attention for symptoms that may have been associated with anaphylaxis. Among the 33 persons who sought medical attention for these symptoms in NJ and NYC, none was hospitalized and none of the symptoms was attributed to antimicrobial prophylaxis by clinicians who evaluated these persons. Follow-up of persons in DC who sought medical attention for symptoms that may have been associated with anaphylaxis is ongoing.

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Editorial Note: Among persons with exposures to *B. anthracis* related to the recent bioterrorist attacks, completion of a full 60-day course of antimicrobial prophylaxis is essential for preventing anthrax (*1*). Activities to promote adherence among postal employees in NJ, NYC, and DC include messages (e.g., posters at the worksite) to promote adherence, small group discussions with postal employees to identify and resolve barriers to adherence, and reminder devices (e.g., pocket calendars). In addition, a key component of promoting adherence is monitoring adverse events that might deter patients from taking antimicrobial prophylaxis. Information from these monitoring systems can be used to reassure workers of antimicrobial prophylaxis and to guide management of workers with potentially serious adverse events.

Although adverse events were commonly reported by postal employees who participated in this evaluation and included gastrointestinal and dermatologic reactions, only 2% of persons surveyed sought medical care for symptoms that may have been associated with anaphylaxis. Overall rates of adverse events (regardless of attributability) in NJ, NYC, and DC are similar to the frequency of adverse events among other persons on antimicrobial prophylaxis for exposures to *B. anthracis* related to these bioterrorist attacks (*2*) and among persons on ciprofloxacin therapy for any indication (*3,4*). The

*The proportion of surveyed postal employees who had initiated prophylaxis varied across sites: 1,643 (99%) in DC, 434 (99%) in NJ, and 1,786 (48%) in NY. In NY, antimicrobial prophylaxis was recommended for approximately 1,800 postal employees who were at increased risk for anthrax and made available to another 2,600 postal employees at lower risk for anthrax.

TABLE 1. Number and percentage of postal employees who reported adverse events 7 to 10 days after receiving anthrax prophylaxis — New Jersey (NJ), New York City (NYC), and the District of Columbia (DC) Metropolitan Area, October 26–November 6, 2001

Antimicrobial and site	No. persons on prophylaxis	Reported severe nausea, vomiting, diarrhea, or abdominal pain		Reported fainting, light-headedness, or dizziness		Reported heartburn or acid reflux		Reported rash, hives, or itchy skin		Required follow-up because of adverse events*		Required hospitalization		Discontinued prophylaxis because of adverse events	
		No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Ciprofloxacin	3,428														
NJ	365	94	(26)	46	(13)	47	(13)	43	(12)	4	(1)	0	(0)	26	(7)
NYC	1,612	231	(14)	166	(10)	89	(6)	86	(5)	25	(2)	0	(0)	63	(4)
DC	1,451	341	(24)	272	(19)	114	(8)	87	(6)	42	(3)	NA†		27	(2)
Doxycycline	232														
NJ	55	10	(18)	4	(7)	11	(20)	6	(11)	2	(4)	0	(0)	0	(0)
NYC	96	11	(11)	1	(1)	4	(4)	2	(2)	2	(2)	0	(0)	1	(1)
DC	81	10	(12)	12	(15)	4	(5)	4	(5)	7	(9)	NA		5	(6)

* Persons who required detailed follow-up reported difficulty breathing; throat tightness and difficulty swallowing; swelling of lips, tongue, or face; or rash, hives, or itchy skin, and sought medical attention for their symptoms.

† Not available.

Adverse Events — Continued

higher rates of adverse events in NJ compared with NYC and DC (p=0.001), may be explained by the different mode of administration of the questionnaires (nurse versus self-administered). Discontinuation of therapy caused by adverse events was similar to other groups previously studied (*5*). Both active and passive monitoring of adverse events and promotion and assessment of adherence to prophylaxis will continue for the duration of the recommended postexposure prophylaxis.

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HIV Testing Among Racial/Ethnic Minorities — United States, 1999

Human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS) in the United States disproportionately affect racial/ethnic minority populations, particularly blacks and Hispanics (*1*). Of the 774,467 AIDS cases reported to CDC during June 1981–December 2000 (*2*), blacks and Hispanics accounted for 56% of cases, although they represented 25% of the U.S. population during this period. In 2000, the incidence of adult and adolescent AIDS cases per 100,000 population was 74.2 for blacks, 30.4 for Hispanics, and 7.9 for whites (*2*). HIV counseling and testing services potentially can reduce the risk for infection with HIV and provide referrals to HIV-infected persons for medical care. An estimated 300,000 HIV-infected persons in the United States may be unaware of their HIV serostatus (*3*). In 2001, CDC introduced the Serostatus Approach to Fighting the Epidemic (SAFE) (*3*), which focuses on increasing the number of high-risk and infected persons who know their serostatus and helps infected persons receive and maintain appropriate medical care and reduce their risk for transmitting infection. CDC analyzed data from the National Health Interview Survey (NHIS) to determine the rate at which racial/ethnic minorities are getting tested for HIV. This report describes the result of the analysis, which indicates that minority populations are being tested for HIV infection at a high rate; however, a substantial number of persons at risk for HIV have not been tested. Prevention programs should continue to develop innovative methods for counseling and testing at-risk persons.

NHIS is an annual, household-based health survey representing the civilian, noninstitutionalized U.S. population aged ≥18 years (*4*). The 1999 NHIS data are based on interviews with 30,801 respondents. The response rate for sample adults was 70%. To determine high-risk behaviors, respondents were asked, "Tell me if any of these statements is true for you: you have hemophilia and have received clotting factor concentrations; you are a man who has had sex with another man at some time since 1980, even one time; you have taken street drugs by needle at any time since 1980; you have traded sex for money or drugs at any time since 1980; since 1980, you are or have been the sex partner of any person who would answer 'yes' to any of the items on this card/any of the items I have read."

HIV Testing — Continued

Two of the outcome measures estimated were the percentage of respondents who reported that they had ever been tested for HIV (excluding testing for blood donation) and the percentage who reported that they had been tested during the 12 months preceding the survey. HIV testing rates were computed separately for HIV risk behavior and perceived risk by race/ethnicity. Percentages were computed using all respondents, including 4.2% who refused, did not answer, or did not know if they had ever been tested. Weighting factors were used to compensate for the effects of nonresponses and unequal selection probabilities. Differences among subgroups were assessed using chi-square tests of difference ($p<0.05$); confidence intervals (CIs) and significance tests were computed using SUDAAN 7.0 to adjust for the effects of the complex survey design.

Among 30,801 respondents, 668 (1.9%) (95% CI=1.7%–2.1%) reported at least one of the HIV risk behaviors on the list and were considered at increased risk for infection. Rating their own perceived risk as high, medium, low, or none, 760 (2.3%; [95% CI=2.1%–2.5%]) stated that they had a high or medium chance of becoming infected with HIV. A total of 1,303 respondents were in either of these risk categories (3.9%; [95% CI=3.6%–4.2%]).

Among the 30,801 respondents, 43.8% (95% CI=43.1%–44.6%) reported that they had ever been tested for HIV, including testing for blood donation. Blacks were significantly more likely to report previous HIV testing (51.6% [95% CI=49.6%–53.8%]) than Hispanics (39.5% [95% CI=37.7%–41.3%]) or whites (43.6% [95% CI=42.8%–44.4%]).

Of all respondents (excluding those tested for blood donation), 30.9% reported having ever been tested for HIV; blacks reported previous testing more frequently (45.5%) than Hispanics (33.1%) or whites (28.5%) (Table 1)*. Among persons who reported any HIV risk behavior, 72.7% reported ever being tested and of persons who perceived a high or medium risk for HIV infection, 54.3% reported ever being tested. Within each racial/ethnic population, more persons who reported any HIV risk behavior were tested than those who did not report any HIV risk behavior, including blacks (82.2%), Hispanics (73.5%), and whites (72.6%). Among those reporting a high or medium perceived risk, past HIV testing was reported more frequently by blacks (70.2%) than Hispanics (62.8%) or whites (50.7%). Testing during the 12 months preceding the survey was reported more frequently by blacks (20.4%) than Hispanics (11.7%) or whites (8.1%) (Table 1). Among persons who reported either HIV risk behavior or high or medium perceived risk, testing during the 12 months preceding the survey was reported more frequently by blacks (39.8%) than Hispanics (27.5%) or whites (22.6%) (Table 1).

Although persons with perceived risk or who reported any HIV risk behavior were more likely than others to be tested, a substantial proportion of this group reported never having been tested for HIV: blacks (26.4% [95% CI=19.5%–33.4%]), Hispanics (35.3% [95% CI=26.1%–44.5%]), and whites (38.9% [95% CI=34.9%–42.9%]) representing an estimated 196,000–380,000 blacks, 188,000–455,000 Hispanics, and 1.8–2.4 million whites. More blacks were tested "just to find out their HIV status," while more whites were tested because it was required for insurance, employment, surgery, or military service (Table 2). Hispanics were equally divided between testing just to find out infection status; testing required for hospitalization, insurance, new job, and other application processes; and testing because it was recommended by a health-care provider or sex partner.

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*Numbers for other racial/ethnic groups were too small for meaningful analysis.

TABLE 1. Percentage* of persons aged ≥18 years who reported ever having had an HIV test (excludes testing for blood donation) and who reported having been tested during the 12 months preceding the survey, by HIV risk, perceived risk, and race/ethnicity — National Health Interview Survey, United States, 1999

	All races/ethnicities			Black			Hispanic			White		
Testing status	No. interviewed	% tested for HIV	(95% CI†)	No. interviewed	% tested for HIV	(95% CI)	No. interviewed	% tested for HIV	(95% CI)	No. interviewed	% tested for HIV	(95% CI)
Ever tested for HIV												
HIV risk behavior												
Yes	668	(72.7)	(68.2–77.3)	97	(82.2)	(72.4–91.9)	96	(73.5)	(60.9–86.1)	448	(72.6)	(67.7–77.5)
No	30,133	(30.1)	(29.4–30.7)	4,131	(44.8)	(42.6–46.9)	4,897	(32.3)	(30.7–34.0)	20,132	(27.7)	(27.0–28.5)
Perceived risk												
High/Medium	760	(54.3)	(50.2–58.4)	147	(70.2)	(61.3–79.1)	122	(62.8)	(51.8–73.8)	455	(50.7)	(45.6–55.9)
Others§	30,041	(30.3)	(29.7–31.0)	4,081	(44.6)	(42.4–46.9)	4,871	(32.3)	(30.7–33.9)	20,125	(28.1)	(27.3–28.8)
Either												
Yes	1,303	(61.1)	(58.0–64.1)	221	(73.3)	(66.4–80.3)	190	(64.5)	(55.2–73.8)	834	(59.5)	(55.6–63.4)
No	29,498	(29.7)	(29.0–30.3)	4,007	(44.1)	(41.9–46.3)	4,803	(31.8)	(30.2–33.4)	19,746	(27.4)	(26.6–28.1)
Total	**30,801**	**(30.9)**	**(30.2–31.5)**	**4,228**	**(45.5)**	**(43.3–47.6)**	**4,993**	**(33.1)**	**(31.4–34.7)**	**20,580**	**(28.5)**	**(27.8–29.3)**
Tested during previous 12 months												
HIV risk behavior												
Yes	668	(30.4)	(26.1–34.7)	97	(49.0)	(36.7–61.3)	96	(28.8)	(19.0–38.5)	448	(28.5)	(23.4–33.5)
No	30,133	(9.5)	(9.1– 9.9)	4,131	(19.9)	(18.3–21.4)	4,897	(11.3)	(10.3–12.4)	20,132	(7.8)	(7.3– 8.2)
Perceived risk												
High/Medium	760	(24.6)	(21.4–27.8)	147	(36.5)	(28.3–44.6)	122	(32.6)	(22.5–42.7)	455	(20.8)	(17.1–24.6)
Others	30,041	(9.6)	(9.1–10.0)	4,081	(19.9)	(18.3–21.5)	4,871	(11.1)	(10.1–12.2)	20,125	(7.9)	(7.4– 8.3)
Either												
Yes	1,303	(25.4)	(22.7–28.1)	221	(39.8)	(32.5–47.1)	190	(27.5)	(19.3–35.7)	834	(22.6)	(19.4–25.8)
No	29,498	(9.3)	(8.9– 9.7)	4,007	(19.4)	(17.8–21.0)	4,803	(11.0)	(10.0–12.1)	19,746	(7.6)	(7.2– 8.0)
Total	**30,801**	**(9.9)**	**(9.5–10.3)**	**4,228**	**(20.4)**	**(18.8–22.1)**	**4,993**	**(11.7)**	**(10.6–12.7)**	**20,580**	**(8.1)**	**(7.7– 8.6)**

* Computed using all respondents, including 4.2% who refused, did not answer, or did not know whether they had ever been tested.
† Confidence interval.
§ Includes persons who stated that their risk for HIV infection was low, none, or did not know, and persons who refused or did not answer.

HIV Testing — Continued

TABLE 2. Reasons for being tested for HIV in persons aged ≥18 years who were tested during the 12 months preceding the survey, by race/ethnicity — National Health Interview Survey, United States, 1999

Race/ Ethnicity	No.	Just to find out infection status (%)	(95% CI[§])	Recommended* (%)	(95% CI)	Required test† (%)	(95% CI)
Black	867	(42.9)	(38.3–47.5)	(28.5)	(24.7–32.3)	(26.1)	(22.5–29.6)
Hispanic	631	(33.9)	(29.5–38.3)	(34.6)	(30.4–38.9)	(31.7)	(27.1–36.3)
White	1,677	(25.5)	(23.1–28.0)	(29.2)	(26.7–31.7)	(38.6)	(35.9–41.4)
Total	**3,274**	**(30.6)**	**(28.5–32.6)**	**(29.4)**	**(27.5–31.3)**	**(35.3)**	**(33.2–37.3)**

* By doctor, sex partner, health department, or for pregnancy.
† For hospitalization/surgery, health/life insurance, health-care provider guidelines, new job, military, or immigration.
§ Confidence interval.

Editorial Note: On the basis of data from the 1999 NHIS, 30.9% of adults in the United States have been tested for HIV (excluding testing for blood donation), an increase from 5% in 1987 and 26% in 1995 (*5*). In the late 1980s, rates of HIV testing (excluding testing for blood donation) were slightly higher for blacks (7%) and Hispanics (7%) than whites (5%) (*6*). The 1999 data indicated a higher rate of HIV testing among minority populations. However, a substantial number of persons at risk for HIV has never been tested.

The findings in this report are subject to at least four limitations. First, self-reported data are subject to recall bias or other reporting errors. Second, highly sensitive information about risk behaviors and perception of risk may be underreported during a face-to-face interview; some persons at high risk may report low risk or low perception of risk. Others may not be fully aware of their partners' current or past high-risk behaviors. Third, there is no information on HIV serostatus of the respondents. Fourth, the survey does not include hospitalized or incarcerated persons.

The number of untested, at-risk persons has important public health implications. These data may be useful in evaluating the SAFE strategy and focusing CDC prevention programs. Persons unaware of their HIV-positive status cannot access HIV therapy and may be spreading infection. In a recent study, approximately 35% of men aged 15–22 years who had had sex with men reported not having been tested for HIV infection and many of these men reported having unprotected sexual intercourse (*7*).

At-risk, untested persons are more likely to be tested if they acknowledge risky behaviors, perceive risk for HIV infection, have access to services and culturally sensitive testing programs, and are guaranteed confidentiality (*8*). In addition, persons are more likely to be tested when HIV counseling and testing are recommended routinely than when testing is based on the person's request (*9*).

HIV testing provides the opportunity for persons to learn their serostatus and to be counseled to adopt risk reduction strategies to prevent getting infected or, if HIV positive, to prevent transmitting the infection to others and to access care. Persons who test HIV positive are more likely to take steps to protect their partners than when they were unaware of their infection (*10*). Although minority populations with the highest HIV incidence were most likely to be tested, a substantial number of persons at risk, regardless of race/ethnicity, remains untested. Prevention programs should continue to develop innovative methods for counseling and testing at-risk persons and to ensure that seropositive persons are referred for appropriate care.

HIV Testing — Continued

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Simultaneous Administration of Varicella Vaccine and Other Recommended Childhood Vaccines — United States, 1995–1999

Live attenuated varicella vaccine (Var) is recommended in the United States for children aged 12–18 months and for susceptible older children, adolescents, and adults (*1*). The Advisory Committee on Immunization Practices recommends that Var be administered either simultaneously with measles-mumps-rubella (MMR) vaccine or separately by ≥30 days (*1*). This report summarizes an evaluation of these recommendations, which found that a decrease in Var effectiveness occurred when Var was administered <30 days after MMR; therefore, as currently recommended, physicians should administer Var simultaneously with MMR or wait at least 30 days if the vaccines are administered separately.

Using the Vaccine Safety Datalink (VSD) project, the effectiveness of Var was assessed when administered simultaneously with or within 30 days of administering MMR; diphtheria and tetanus toxoids and pertussis vaccine (DTP); *Haemophilus influenzae* type B vaccine (Hib); oral poliovirus vaccine (OPV); inactivated poliovirus vaccine (IPV); and hepatitis B vaccine (HepB). VSD links computerized vaccination records to clinic and hospital discharge records of children from several large health maintenance organizations (HMOs) in the United States (*2*). VSD has expanded from four to seven HMOs and includes an estimated 2.5% of the U.S. population.

A retrospective cohort study was conducted among children from the two HMOs in the VSD project with the earliest available automated clinic data and the highest uptake of Var. Children included in the study cohort were those who received Var at age

Varicella Vaccine — Continued

≥12 months during January 1995–December 1999 at HMO A and during January 1996–December 1999 at HMO B. The effectiveness (or failure) of Var can be measured by the proportion of vaccinated children who develop varicella breakthrough infections (i.e., cases of varicella that occur following exposure to wild-type virus) >42 days after Var; each recommended vaccine was compared with the incidence of breakthrough varicella in children who received Var simultaneously with the vaccine, children who received Var <30 days after the vaccine, and control children who received Var ≥30 days before or after the vaccine.

To identify breakthrough disease, clinic and hospital discharge records from both HMOs were screened for having the same *International Classification of Diseases, Ninth Revision, (ICD-9)* codes* for varicella. Automated telephone contact records available at HMO B also were screened for reports of varicella. Cox proportional hazards models were used to estimate the relative risks (RRs) for breakthrough disease between children receiving Var and other recommended childhood vaccines at different intervals, group-matched on year of birth, year and month of vaccination, and HMO membership.

A cohort was identified of 104,192 children vaccinated with Var from HMO A and 10,482 from HMO B. The median age of children receiving Var was 15 months (range: 12–71 months). The median follow-up time after Var was administered was 20 months (range: 1 day–4.5 years). The number of children aged ≥12 months receiving other vaccines simultaneously with Var, receiving Var before 30 days following other vaccines, and receiving Var ≥30 days before or after other vaccines also were identified (Table 1). The median age and age range were not available for vaccines other than Var.

The simultaneous administration with Var of the vaccines studied did not increase the risk for breakthrough disease (Table 2). Receipt of Var <30 days following MMR was associated with a 2.5-fold increase in the incidence of breakthrough disease (95% confidence interval [CI]=1.3–4.9). Receipt of Var <30 days following any of the other vaccines did not increase the risk for breakthrough disease.

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Editorial Note: No adverse effects have been reported of simultaneous administration of DTP, Hib, MMR, and OPV on the immunogenicity of Var (*3–6*), and the absence of increased risk for breakthrough varicella among children receiving MMR, DTP, Hib, OPV, IPV or HepB simultaneously with Var confirms these findings. Recommendations that caution against the use of Var and MMR within 30 days of each other (*1*) are based on the reported reduction in responsiveness to smallpox vaccine following measles vaccine (*7*). Findings in this report indicate an increased risk for breakthrough disease in children who received Var <30 days after MMR. No increase in breakthrough disease was noted in children who were administered Var <30 days after any of the other vaccines.

The findings in this report are subject to at least two limitations. First, the VSD database contains only information on medical encounters. The number of cases of breakthrough varicella, which is usually mild and not brought to medical attention (*8*), may be underestimated; however, this underestimation is not likely to differ by vaccine administration schedules. Second, misclassification of cases might have occurred during the assignment of *ICD-9* codes.

*Code 052.

Varicella Vaccine — Continued

TABLE 1. Number of children aged ≥12 months who received varicella vaccine (Var) and another vaccine, by vaccine and interval to Var — California and Oregon, 1995–1999

Vaccine*	No.	Simultaneous with Var		Var <30 days after		Var ≥30 days before or after	
		No.	%	No.	%	No.	%
MMR	112,847	78,595	(68.5)	767	(0.7)	33,485	(29.2)
DTP	106,636	48,930	(42.7)	849	(0.7)	56,857	(49.6)
Hib	69,691	33,673	(29.4)	573	(0.5)	35,445	(30.9)
OPV	46,824	17,756	(15.5)	341	(0.3)	28,727	(25.1)
IPV	9,859	4,810	(4.2)	118	(0.1)	4,931	(4.3)
HepB	19,917	7,368	(6.4)	441	(0.4)	12,108	(10.6)

* MMR: combined measles-mumps-rubella vaccine; DTP: diphtheria and tetanus toxoids and pertussis vaccine; Hib: *Haemophilus influenzae* type B vaccine; OPV: oral poliovirus vaccine; IPV: inactivated poliovirus vaccine; HepB: hepatitis B vaccine.

TABLE 2. Relative risk (RR) of infection with breakthrough varicella in children aged ≥12 months associated with receiving another vaccine <30 days preceding varicella vaccine (Var) or simultaneously compared with receiving Var ≥30 days before or after another vaccine, by vaccine — California and Oregon, 1995–1999

Vaccine*	Simultaneous with Var		Var <30 days later	
	RR	(CI†)	RR	(CI)
MMR	1.1	(0.9–1.4)	2.5§	(1.3–4.9)
DTP	1.1	(0.9–1.3)	1.0	(0.4–2.6)
Hib	1.1	(0.8–1.3)	0.4	(0.1–2.6)
OPV	1.1	(0.8–1.5)	1.6	(0.5–5.1)
IPV	2.1	(0.5–8.4)	—¶	
HepB	1.2	(0.7–1.9)	2.3	(0.8–6.7)

* MMR: combined measles-mumps-rubella vac)cine; DTP: diphtheria and tetanus toxoids and pertussis vaccine; Hib: *Haemophilus Influenzae* type B vaccine; OPV: oral poliovirus vaccine; IPV: inactivated poliovirus vaccine; HepB: hepatitis B vaccine.
† Confidence interval.
§ RR significant.
¶ Numbers were too small for meaningful analysis.

No evidence was found that simultaneous administration of MMR, DTP, Hib, OPV, IPV, or HepB and Var increases the risk for breakthrough disease. To minimize the number of visits needed for immunization, Var should be administered simultaneously with these vaccines or should follow administration of MMR by ≥30 days.

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Varicella Vaccine — Continued

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Weekly Update: West Nile Virus Activity — United States, November 14–20, 2001

The following report summarizes West Nile virus (WNV) surveillance data reported to CDC through ArboNET and verified by states and other jurisdictions as of November 20, 2001.

During the week of November 14–20, three human cases of WNV encephalitis or meningitis were reported from Massachusetts (two) and New Jersey (one). During the same period, WNV infections were reported in 87 crows, 23 other birds, and 13 horses. A total of three WNV-positive mosquito pools were reported from two states (Georgia and Ohio).

During 2001, a total of 48 human cases of WNV encephalitis or meningitis have been reported in New York (12), Florida (10), New Jersey (seven), Connecticut (six), Maryland (six), Pennsylvania (three), Massachusetts (two), Georgia (one), and Louisiana (one). Among these 48 cases, 27 (56%) were in males; the median age was 70 years (range: 36–90 years); dates of illness onset ranged from July 13 to October 15; and five (10%) patients died. A total of 4,604 crows and 1,497 other birds with WNV infection were reported from 27 states and the District of Columbia (Figure 1); 189 WNV infections in other animals (all horses) were reported from 15 states (Alabama, Connecticut, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Massachusetts, Mississippi, New York, North Carolina, Pennsylvania, Tennessee, and Virginia). During 2001, 756 WNV-positive mosquito pools were reported from 15 states (Connecticut, Florida, Georgia, Illinois, Kentucky, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, and Virginia) and the District of Columbia.

Additional information about WNV activity is available at <http://www.cdc.gov/ncidod/dvbid/westnile/index.htm> and <http://cindi.usgs.gov/hazard/event/west_nile/west_nile.html>. Because WNV season is ending, this is the last week of publication of the weekly updates on WNV activity. A full report on WNV surveillance will be published in *MMWR* at a later date.

West Nile Virus — Continued

FIGURE 1. Areas reporting West Nile virus (WNV) activity — United States, 2001*

* As of November 20, 2001.

Notice to Readers

World AIDS Day — December 1, 2001

"I care, do you?" is the theme designated by the Joint United Nations Program on Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS) for this year's World AIDS Day, December 1, 2001. This year's theme highlights the impact of HIV on youth and encourages young persons to learn about and to become more involved in the prevention, diagnosis, and treatment of HIV/AIDS.

As of June 2001, AIDS was reported among 793,026 persons in the United States; of these, 41,093 (5.2%) were aged <25 years at time of diagnosis (*1*). During July 2000–June 2001, a total of 3,398 (15.4%) persons aged 13–24 years were newly reported with HIV infection from the 36 areas with confidential HIV reporting (*1*). In addition, youth are at high risk for acquiring other sexually transmitted infections. In 2000, persons aged 15–24 years accounted for 74% of reported chlamydia, 60% of gonorrhea, and 22% of early syphilis cases (*2*). Effective HIV prevention interventions among youth may set lifelong patterns of sexual safety and responsibility. Increasing the proportion of youth who consistently engage in behaviors that reduce the risk for HIV acquisition or transmission is a key objective of CDC's 5-year HIV Prevention Strategic Plan to reduce new HIV infections in the United States (*3*).

The estimated number of AIDS cases diagnosed each year among children (i.e., aged <13 years) has declined consistently, from a peak of 949 in 1992 to 105 cases in 2000 (*1*). Declines in AIDS incidence among U.S. children are associated with the implementation of U.S. Public Health Service recommendations for use of zidovudine to reduce perinatal transmission (*4*).

Notices to Readers — Continued

Globally, an estimated 620,000 children aged <15 years were newly infected with HIV, and 500,000 children died of AIDS in 1999 (*5*). However, improving access to and use of interventions, including abbreviated antiretroviral regimens to prevent perinatal HIV transmission, may help decrease the number of infections in children. CDC's Global AIDS Program, in collaboration with other U.S. agencies, UNAIDS, and other international agencies, is assisting ministries of health to implement widespread use of these regimens (*6*) as part of its wider support for programs to prevent HIV, provide home- and community-based care for HIV-infected persons, and enhance surveillance, laboratory, and other infrastructures in 24 countries.

Additional information about World AIDS Day, HIV infection, and AIDS is available at <http://www.cdc.gov/hiv> and <http://www.unaids.org>. Information about the U.S. epidemic is available at 800-342-AIDS or in Spanish at 800-244-7432.

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Notice to Readers

National Drunk and Drugged Driving Prevention Month — December 2001

December has been designated by Presidential proclamation as National Drunk and Drugged Driving Prevention Month (3D Month). 3D Month is supported by many public and private sector organizations devoted to preventing impaired driving crashes. During 2000, alcohol-related motor-vehicle crashes resulted in 16,653 deaths in the United States (*1*). On the basis of data provided by the National Highway Traffic Safety Administration (NHTSA) (*1*) and the U.S. Bureau of the Census (*2*), the rate of alcohol-related traffic fatalities in 2000 was 5.9 per 100,000 persons. One of the national health objectives for 2010 is a target for alcohol-related traffic fatalities of no more than 4.0 per 100,000 persons (objective 26-1A) (*3*). To meet this objective, the annual rate of alcohol-related traffic fatalities must decline by 32%.

CDC recently concluded a systematic review of the effectiveness of five community-based interventions to reduce alcohol-impaired driving: sobriety checkpoints; 0.08% blood alcohol concentration laws; minimum legal drinking age laws; "zero tolerance" laws for young or inexperienced drivers; and server intervention training programs*. All five interventions showed evidence of effectiveness (*4*) and each was recommended for

*Available at <http://www.thecommunityguide.org>.

Notices to Readers — Continued

implementation by the Task Force on Community Preventive Services (*5,6*), an independent, nonfederal panel of community-health consultants. Broader use of such strategies will be necessary to achieve the 2010 objective of reducing alcohol-related traffic fatalities.

The theme for this year's 3D Month is "This holiday season...the greatest gift you can give may be a ride home." The 3D Month program planner, which contains sample public service announcements, media tool kits, and program guidance for conducting 3D Month activities, is available from NHTSA at <http://www.nhtsa.dot.gov> or on CD-ROM, by faxing a request to 301-386-2194.

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Notice to Readers

Alcohol Involvement in Fatal Motor-Vehicle Crashes — United States, 1999–2000

The following table compares alcohol involvement in fatal motor-vehicle crashes by age group and blood alcohol concentration (BAC) levels for 1999 and 2000. A fatal crash is considered alcohol-related by the National Highway Traffic Safety Administration (NHTSA) if either a driver or nonoccupant (e.g., pedestrian) had a BAC of ≥0.01 g/dL in a police-reported traffic crash. Because BACs are not available for all persons in fatal crashes, NHTSA estimates the number of alcohol-related traffic fatalities on the basis of a discriminant analysis of information from all cases for which driver or nonoccupant BAC data are available (*1*).

Overall during 1999–2000, the number of alcohol-related traffic fatalities increased by 4% (95% confidence interval [CI]=2%–7%). For BACs ≥0.10 g/dL (the legal limit for intoxication in most states in 1999 and 2000), fatalities increased by 4% (95% CI=1%–6%); for BACs of 0.01–0.09 g/dL, fatalities increased by 7% (95% CI=2%–12%). A broad range of public health and traffic safety strategies will be needed to stem further increases and reduce the number of alcohol-related traffic fatalities (*2*).

Notices to Readers — Continued

References

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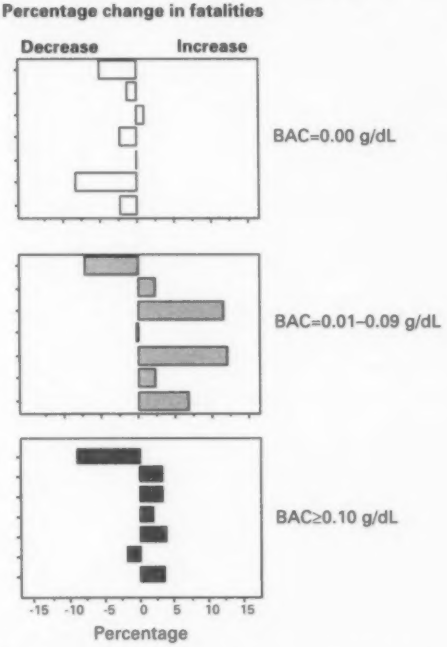
Changes in the estimated number and percentage of traffic fatalities (including drivers, occupants, and nonoccupants), by age group* and highest blood alcohol concentration (BAC)† of drivers§ or nonoccupants in crashes — United States, January1–December 31, 1999, compared with January 1–December 31, 2000

Age group (yrs)	No. fatalities 1999	No. fatalities 2000
BAC=0.00 g/dL		
<15	1,966	1,869
15–20	4,105	4,051
21–24	1,761	1,780
25–34	3,183	3,109
35–64	8,532	8,521
>65¶	6,144	5,648
Total¶,**	**25,741**	**25,168**
BAC=0.01–0.09 g/dL		
<15	182	169
15–20	686	701
21–24	459	512
25–34	662	661
35–64¶	1,183	1,323
>65	344	352
Total¶,**	**3,523**	**3,761**
BAC≥0.10 g/dL		
<15	335	305
15–20	1,587	1,638
21–24	1,675	1,731
25–34	2,988	3,051
35–64	5,184	5,383
>65	654	643
Total¶,**	**12,453**	**12,892**



* Age of decedent was unknown for 87 traffic fatalities in 1999 and 374 in 2000. Decedents of unknown age were included in the calculations of the total number of fatalities by BAC level.

† BAC distributions are estimates for drivers and nonoccupants involved in fatal crashes. Fatalities include all occupants and nonoccupants who died within 30 days after a motor-vehicle crash on a public roadway.

§ Driver may not have been killed.

¶ Percentage change statistically significant at p=0.05.

** The number of fatalities for each BAC category is rounded to the nearest whole number.

Source: Fatality Analysis Reporting System, National Highway Traffic Safety Administration.

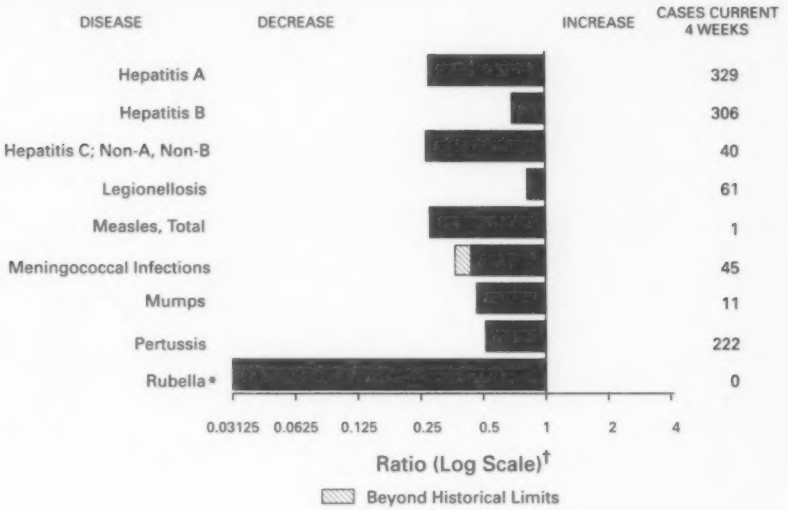
Erratum: Vol. 50, No. 40

In the article "Cigarette Smoking Among Adults—United States, 1999," on page 871, Figure 1, the source line should read, "Sample adult core component of the National Health Interview Survey. Estimate for *2001* based on data collected during January–*March 2001*.

Erratum: Vol. 50, No. 21

In the article "HIV and AIDS—United States, 1981–2000," on page 431 in Table 1, the number of white non-Hispanic persons with AIDS reported during 1996–2000 should be *89,896*, and the number of persons with AIDS reported for U.S. territories during 1993–1995 should be *8,182*. The percentage of black, non-Hispanic persons with AIDS reported during 1988–1992 should be *31.3%*. On page 443, in the last sentence of the first paragraph, the estimated number of cases of perinatally acquired AIDS diagnosed in 1999 should be *156*.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending November 24, 2001, with historical data



* No rubella cases were reported for the current 4-week period yielding a ratio for week 47 of zero (0).

† Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending November 24, 2001 (47th Week)*

	Cum. 2001		Cum. 2001
Anthrax	14	Poliomyelitis, paralytic	-
Brucellosis†	76	Psittacosis†	22
Cholera	3	Q fever†	20
Cyclosporiasis†	128	Rabies, human	1
Diphtheria	2	Rocky Mountain spotted fever (RMSF)	553
Ehrlichiosis: human granulocytic (HGE)†	188	Rubella, congenital syndrome	-
human monocytic (HME)†	82	Streptococcal disease, invasive, group A	3,222
Encephalitis: California serogroup viral†	99	Streptococcal toxic-shock syndrome†	43
eastern equine†	8	Syphilis, congenital§	190
St. Louis†	1	Tetanus	23
western equine†	-	Toxic-shock syndrome	104
Hansen disease (leprosy)†	76	Trichinosis	25
Hantavirus pulmonary syndrome†	6	Tularemia†	96
Hemolytic uremic syndrome, postdiarrheal†	135	Typhoid fever	248
HIV infection, pediatric†¶	181	Yellow fever	-
Plague	2		

-: No reported cases.
*Incidence data for reporting year 2001 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
¶ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP). Last updated October 30, 2001.
§ Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending November 24, 2001, and November 25, 2000 (47th Week)*

Reporting Area	AIDS		Chlamydia†		Cryptosporidiosis		*Escherichia coli* O157:H7†			
							NETSS		PHLIS	
	Cum. 2001§	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	33,013	32,692	641,362	625,027	3,033	2,791	2,790	4,200	2,133	3,461
NEW ENGLAND	1,276	1,673	21,053	21,220	117	129	216	361	219	367
Maine	40	28	1,187	1,312	18	20	26	31	26	28
N.H.	31	28	1,225	996	15	22	35	35	29	38
Vt.	13	29	561	484	31	26	13	34	8	35
Mass.	661	1,049	8,915	9,079	49	34	113	159	109	164
R.I.	86	81	2,668	2,420	4	3	14	19	11	18
Conn.	446	458	6,497	6,929	-	24	15	83	36	84
MID. ATLANTIC	7,683	7,090	73,540	59,047	253	354	203	413	181	328
Upstate N.Y.	823	665	13,089	2,810	103	116	150	277	136	70
N.Y. City	3,788	3,755	26,709	23,766	87	159	12	23	11	18
N.J.	1,537	1,423	10,547	9,446	11	19	41	113	34	113
Pa.	1,535	1,247	23,195	23,025	52	60	N	N	-	127
E.N. CENTRAL	2,513	3,164	105,225	108,306	1,381	922	729	1,025	489	724
Ohio	482	475	21,840	28,311	157	252	200	253	151	220
Ind.	306	320	13,618	12,183	79	57	80	118	42	83
Ill.	1,115	1,596	30,000	30,074	399	117	152	188	128	155
Mich.	459	601	27,025	23,001	168	91	90	138	80	104
Wis.	151	172	12,742	14,737	578	405	207	328	88	162
W.N. CENTRAL	719	762	31,468	35,351	419	345	514	612	444	588
Minn.	121	153	6,456	7,357	176	123	242	168	212	201
Iowa	78	73	3,944	4,651	78	74	80	176	62	147
Mo.	347	349	11,275	12,065	44	29	61	106	86	96
N. Dak.	2	2	804	789	13	15	18	18	32	21
S. Dak.	23	7	1,625	1,651	7	15	42	55	41	58
Nebr.	63	64	2,193	3,339	98	80	52	61	-	48
Kans.	85	114	5,171	5,499	3	9	19	28	11	17
S. ATLANTIC	10,366	9,072	121,259	117,326	311	441	213	350	138	278
Del.	218	182	2,309	2,587	6	6	4	3	7	1
Md.	1,529	1,127	10,876	12,534	38	9	27	32	1	2
D.C.	738	694	2,642	2,873	11	16	-	1	U	U
Va.	803	580	16,245	13,997	24	18	48	69	39	64
W. Va.	73	54	2,111	1,938	2	3	10	15	8	13
N.C.	807	585	18,577	19,795	27	25	46	87	42	68
S.C.	623	682	9,919	8,809	7	-	16	21	11	16
Ga.	1,239	1,049	26,441	25,034	127	164	30	39	15	38
Fla.	4,336	4,119	32,139	29,759	69	200	32	83	15	76
E.S. CENTRAL	1,554	1,618	43,786	45,839	46	48	125	140	108	113
Ky.	299	168	7,707	7,246	4	6	58	40	49	32
Tenn.	507	684	12,988	13,287	13	11	42	53	44	52
Ala.	378	418	12,763	13,933	16	15	17	10	6	9
Miss.	370	348	10,328	11,373	13	16	8	37	9	20
W.S. CENTRAL	3,488	3,366	93,579	94,204	36	155	90	222	91	274
Ark.	178	158	6,234	5,886	8	14	13	56	-	38
La.	711	587	15,576	16,383	7	12	4	15	26	47
Okla.	203	294	9,205	8,485	14	17	31	19	28	17
Tex.	2,396	2,327	62,564	63,450	7	112	42	132	37	172
MOUNTAIN	1,172	1,211	36,845	34,308	223	167	269	404	130	301
Mont.	15	12	1,746	1,252	37	10	20	30	-	-
Idaho	19	19	1,723	1,682	22	23	67	69	-	40
Wyo.	3	9	747	726	7	5	7	19	1	11
Colo.	248	294	8,723	8,948	36	69	88	153	53	109
N. Mex.	129	126	5,202	4,645	27	20	14	22	10	18
Ariz.	459	386	12,903	11,447	7	10	28	48	23	42
Utah	101	113	1,537	2,069	82	26	30	49	42	71
Nev.	198	252	4,264	3,539	5	4	15	14	1	10
PACIFIC	4,242	4,736	114,607	109,426	247	230	431	673	333	488
Wash.	435	428	12,187	11,690	-	U	122	219	62	200
Oreg.	177	145	6,530	6,131	49	20	64	131	59	113
Calif.	3,552	4,042	90,111	86,094	194	210	224	278	203	158
Alaska	18	22	2,317	2,278	1	-	4	31	1	6
Hawaii	60	99	3,462	3,233	3	-	17	14	8	11
Guam	12	13	-	452	-	-	N	N	U	U
P.R.	1,021	1,133	2,240	U	-	-	1	6	U	U
V.I.	2	31	53	-	-	-	-	-	U	U
Amer. Samoa	1	-	U	U	U	U	U	U	U	U
C.N.M.I.	-	-	124	U	-	U	-	U	U	U

N: Not notifiable. U: Unavailable. -: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.

* Incidence data for reporting year 2001 are provisional and cumulative (year-to-date). Incidence data for reporting year 2000 are finalized and cumulative (year-to-date).

† Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

‡ Chlamydia refers to genital infections caused by *C. trachomatis*.

§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last updated October 30, 2001.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending November 24, 2001, and November 25, 2000 (47th Week)*

Reporting Area	Gonorrhea		Hepatitis C; Non-A, Non-B		Legionellosis		Listeriosis	Lyme Disease	
	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2001	Cum. 2000
UNITED STATES	295,842	320,572	2,917	2,853	931	995	429	11,404	15,514
NEW ENGLAND	6,036	5,972	15	29	69	53	39	3,727	5,040
Maine	119	82	-	2	9	2	2	-	-
N.H.	168	96	-	-	10	3	4	138	60
Vt.	62	60	7	4	5	5	3	15	40
Mass.	2,796	2,483	8	18	21	17	24	826	1,134
R.I.	765	591	-	5	10	9	1	449	550
Conn.	2,126	2,660	-	-	14	17	5	2,299	3,256
MID. ATLANTIC	38,127	35,245	1,449	631	181	279	64	5,637	8,051
Upstate N.Y.	7,958	6,721	53	37	62	84	26	3,311	3,498
N.Y. City	11,359	10,426	-	-	24	46	11	2	177
N.J.	7,198	6,435	1,342	551	13	22	12	927	2,410
Pa.	11,612	11,663	54	43	82	128	15	1,397	1,966
E.N. CENTRAL	55,171	64,469	149	214	274	257	64	633	762
Ohio	12,193	17,465	5	12	122	106	15	110	58
Ind.	6,090	5,722	1	-	22	35	8	23	22
Ill.	16,669	18,942	13	19	19	30	11	21	35
Mich.	15,593	16,035	130	183	75	48	23	13	23
Wis.	4,626	6,305	-	-	36	38	7	466	624
W.N. CENTRAL	13,418	16,127	673	546	48	55	19	361	366
Minn.	2,079	2,885	9	5	9	7	2	296	267
Iowa	1,016	1,133	-	2	8	13	2	36	32
Mo.	7,047	7,941	651	528	21	25	10	24	46
N. Dak.	35	64	-	-	1	-	-	-	1
S. Dak.	255	259	-	-	3	2	-	-	-
Nebr.	713	1,346	4	4	5	4	1	3	4
Kans.	2,273	2,499	9	7	1	4	4	2	17
S. ATLANTIC	74,877	83,279	97	99	183	181	66	785	1,042
Del.	1,398	1,560	-	2	12	10	-	49	167
Md.	6,121	8,701	16	12	35	65	14	506	603
D.C.	2,417	2,402	-	3	8	6	-	16	10
Va.	9,605	9,398	-	3	21	32	12	115	140
W. Va.	643	592	9	15	N	N	5	13	31
N.C.	15,079	16,202	19	17	11	15	5	38	44
S.C.	6,622	7,680	6	3	13	6	5	5	13
Ga.	14,570	16,386	1	3	10	7	11	-	-
Fla.	18,422	20,358	46	41	73	40	14	43	34
E.S. CENTRAL	28,445	33,084	171	420	53	36	20	57	48
Ky.	3,089	3,188	8	34	11	19	5	22	11
Tenn.	8,719	10,578	59	92	27	10	8	26	28
Ala.	9,876	10,967	4	10	13	4	7	8	6
Miss.	6,761	8,351	100	284	2	3	-	1	3
W.S. CENTRAL	45,704	49,733	177	677	9	23	18	82	86
Ark.	3,881	3,467	4	8	-	-	1	1	5
La.	10,625	12,114	88	415	2	7	-	2	7
Okla.	4,212	3,782	4	9	3	3	2	-	1
Tex.	26,986	30,370	81	245	4	13	15	79	73
MOUNTAIN	9,077	9,468	63	69	51	41	35	13	12
Mont.	98	47	1	5	-	1	-	-	-
Idaho	69	83	2	3	3	5	1	5	2
Wyo.	77	44	8	2	1	-	2	1	3
Colo.	2,756	2,866	21	13	15	14	8	3	-
N. Mex.	877	1,028	11	13	3	1	7	-	-
Ariz.	3,508	3,802	9	18	19	7	8	1	-
Utah	120	209	3	1	6	12	2	1	3
Nev.	1,572	1,389	8	14	4	1	7	2	4
PACIFIC	24,987	23,195	123	168	63	70	104	109	107
Wash.	2,719	2,095	22	31	10	17	10	8	9
Oreg.	1,004	898	12	25	N	N	9	9	12
Calif.	20,358	19,450	89	110	49	52	79	90	84
Alaska	374	320	-	-	-	-	-	2	2
Hawaii	532	432	-	2	4	1	6	N	N
Guam	-	50	-	3	-	-	-	-	-
P.R.	541	463	1	1	2	1	-	N	N
V.I.	6	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	-	U	U
C.N.M.I.	14	U	-	U	-	U	-	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.

* Incidence data for reporting year 2001 are provisional and cumulative (year-to-date). Incidence data for reporting year 2000 are finalized and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending November 24, 2001, and November 25, 2000 (47th Week)*

Reporting Area	Malaria		Rabies, Animal		Salmonellosis†			
					NETSS		PHLIS	
	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	1,131	1,339	7,144	6,419	32,870	35,552	26,807	29,645
NEW ENGLAND	77	69	670	768	2,197	2,018	2,069	2,059
Maine	4	6	63	126	161	117	150	91
N.H.	2	1	22	21	160	134	144	137
Vt.	1	3	59	55	73	103	63	99
Mass.	35	32	245	259	1,249	1,160	1,096	1,174
R.I.	9	8	65	53	122	124	164	138
Conn.	26	19	216	254	432	380	452	420
MID. ATLANTIC	328	361	1,107	1,212	3,930	4,608	3,578	4,879
Upstate N.Y.	64	72	726	770	1,143	1,132	1,213	1,192
N.Y. City	195	208	29	18	991	1,111	1,287	1,199
N.J.	35	47	178	182	834	1,072	657	945
Pa.	34	34	174	242	962	1,293	421	1,543
E.N. CENTRAL	130	135	141	151	4,383	4,907	3,802	3,338
Ohio	22	20	50	50	1,183	1,379	1,076	1,342
Ind.	16	6	15	-	489	593	450	564
Ill.	33	63	24	22	1,201	1,402	1,049	203
Mich.	39	31	46	68	754	821	767	865
Wis.	20	15	6	11	756	712	460	364
W.N. CENTRAL	32	64	323	497	2,121	2,200	2,261	2,373
Minn.	6	27	43	83	599	498	665	638
Iowa	7	2	74	72	328	338	301	329
Mo.	12	17	41	50	604	662	888	809
N. Dak.	-	2	37	107	56	55	80	74
S. Dak.	-	1	42	88	144	91	118	100
Nebr.	2	8	4	2	130	204	-	137
Kans.	5	7	82	95	260	352	209	286
S. ATLANTIC	267	302	2,067	2,194	7,987	7,439	5,544	5,482
Del.	2	5	30	49	87	110	98	124
Md.	108	105	332	387	745	709	827	653
D.C.	13	16	-	-	78	61	U	U
Va.	45	49	449	531	1,218	926	958	867
W. Va.	1	4	131	109	127	152	130	142
N.C.	17	34	539	528	1,257	1,026	1,186	1,053
S.C.	7	2	109	146	820	701	677	529
Ga.	30	26	311	302	1,588	1,424	1,210	1,615
Fla.	44	61	166	142	2,067	2,330	458	499
E.S. CENTRAL	33	44	193	195	2,437	2,217	1,715	1,683
Ky.	12	16	27	20	340	355	217	245
Tenn.	11	11	101	99	584	589	738	757
Ala.	6	14	63	75	707	616	474	563
Miss.	4	1	2	1	806	657	286	118
W.S. CENTRAL	12	68	2,080	839	3,438	4,617	2,537	2,829
Ark.	3	3	20	20	843	676	92	554
La.	5	12	3	4	333	833	952	703
Okla.	3	8	57	53	446	359	375	281
Tex.	1	45	2,000	762	1,816	2,749	1,118	1,291
MOUNTAIN	54	49	231	261	1,974	2,529	1,634	2,348
Mont.	3	1	38	64	72	90	-	-
Idaho	3	3	28	9	128	113	4	108
Wyo.	-	-	20	55	55	65	52	57
Colo.	21	24	-	-	545	658	566	640
N. Mex.	3	-	14	20	268	220	215	196
Ariz.	11	9	115	94	554	676	582	713
Utah	4	6	15	10	203	456	192	453
Nev.	9	6	1	9	149	251	23	181
PACIFIC	198	247	332	302	4,403	5,017	3,667	4,654
Wash.	11	32	-	-	477	545	491	618
Oreg.	13	38	3	7	219	271	292	332
Calif.	164	167	292	267	3,329	3,925	2,526	3,446
Alaska	1	-	37	28	42	56	28	33
Hawaii	9	10	-	-	336	220	330	225
Guam	-	2	-	-	-	26	U	U
P.R.	4	5	85	72	515	623	U	U
V.I.	-	-	-	-	-	-	U	U
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	14	U	U	U

N: Not notifiable. U: Unavailable. -: No reported cases.

* Incidence data for reporting year 2001 are provisional and cumulative (year-to-date). Incidence data for reporting year 2000 are finalized and cumulative (year-to-date).

† Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending November 24, 2001, and November 25, 2000 (47th Week)*

Reporting Area	Shigellosis† NETSS Cum. 2001	Shigellosis† NETSS Cum. 2000	Shigellosis† PHLIS Cum. 2001	Shigellosis† PHLIS Cum. 2000	Syphilis (Primary & Secondary) Cum. 2001	Syphilis (Primary & Secondary) Cum. 2000	Tuberculosis Cum. 2001	Tuberculosis Cum. 2000
UNITED STATES	15,946	20,432	7,351	11,709	5,236	5,471	10,937	12,787
NEW ENGLAND	246	379	264	359	57	78	366	377
Maine	6	10	2	11	1	1	3	16
N.H.	6	6	4	8	1	2	16	18
Vt.	7	4	5	-	3	-	4	4
Mass.	193	264	179	243	33	56	213	212
R.I.	17	30	25	31	9	4	35	28
Conn.	17	65	49	66	10	15	95	99
MID. ATLANTIC	1,146	2,446	711	1,609	437	254	2,075	2,029
Upstate N.Y.	448	713	113	210	23	9	320	291
N.Y. City	328	897	349	610	251	110	1,045	1,083
N.J.	185	486	184	418	127	63	447	489
Pa.	185	350	65	371	36	72	263	166
E.N. CENTRAL	3,896	3,891	1,694	1,186	928	1,115	1,210	1,291
Ohio	2,661	375	1,127	300	71	66	235	250
Ind.	213	1,458	42	150	146	326	98	130
Ill.	468	1,112	288	114	314	385	564	620
Mich.	285	629	210	567	375	294	240	214
Wis.	269	317	27	55	22	44	73	77
W.N. CENTRAL	1,786	2,275	1,247	1,901	79	61	410	468
Minn.	417	741	440	832	28	15	208	144
Iowa	352	500	290	329	4	11	34	33
Mo.	300	618	202	443	20	27	121	176
N. Dak.	21	42	34	49	-	-	3	2
S. Dak.	556	7	246	4	-	-	12	16
Nebr.	74	138	-	116	5	2	32	23
Kans.	66	229	35	128	22	6	-	74
S. ATLANTIC	2,266	2,738	734	1,091	1,795	1,833	2,246	2,537
Del.	15	24	11	21	9	8	15	14
Md.	141	182	90	109	236	281	202	222
D.C.	53	74	U	U	33	36	51	29
Va.	390	429	175	338	96	121	228	240
W. Va.	8	13	8	8	4	3	26	28
N.C.	316	355	166	252	411	448	307	345
S.C.	240	129	120	87	207	209	153	238
Ga.	366	240	130	172	335	355	418	541
Fla.	737	1,292	34	104	464	372	846	880
E.S. CENTRAL	1,463	1,096	564	538	591	798	720	818
Ky.	664	473	300	108	43	78	105	109
Tenn.	93	334	104	358	297	479	265	304
Ala.	198	87	130	65	121	111	240	273
Miss.	508	202	30	7	130	130	110	132
W.S. CENTRAL	2,072	3,247	1,146	1,055	666	750	776	1,884
Ark.	522	193	155	57	35	95	139	166
La.	129	267	166	176	157	196	-	200
Okla.	86	116	36	43	60	108	125	135
Tex.	1,335	2,671	789	779	414	351	512	1,383
MOUNTAIN	882	1,152	660	808	203	212	454	463
Mont.	8	7	-	-	-	-	14	17
Idaho	39	44	-	25	1	1	8	8
Wyo.	3	5	5	3	1	1	3	4
Colo.	222	247	255	202	21	8	108	73
N. Mex.	113	155	75	107	17	16	24	39
Ariz.	373	498	264	324	147	180	201	193
Utah	58	76	53	81	8	1	33	41
Nev.	66	120	8	66	8	5	63	88
PACIFIC	2,189	3,208	331	3,162	480	370	2,680	2,920
Wash.	197	419	167	391	43	60	215	230
Oreg.	81	157	102	107	13	11	97	89
Calif.	1,844	2,591	-	2,631	412	298	2,186	2,380
Alaska	7	7	6	3	-	-	46	99
Hawaii	60	34	56	30	12	1	136	122
Guam	-	37	U	U	-	3	-	49
P.R.	8	33	U	U	249	149	76	135
V.I.	-	-	U	U	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	7	U	U	U	10	U	32	U

N: Not notifiable. U: Unavailable. -: No reported cases.

* Incidence data for reporting year 2001 are provisional and cumulative (year-to-date). Incidence data for reporting year 2000 are finalized and cumulative (year-to-date).

† Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

TABLE III. Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending November 24, 2001, and November 25, 2000 (47th Week)*

Reporting Area	*H. influenzae*, Invasive		Hepatitis (Viral), By Type				Measles (Rubeola)					
			A		B		Indigenous		Imported†		Total	
	Cum. 2001§	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	2001	Cum. 2001	2001	Cum. 2001	Cum. 2001	Cum. 2000
UNITED STATES	1,178	1,175	9,044	11,863	5,893	6,373	-	51	-	44	95	75
NEW ENGLAND	86	97	582	360	90	101	-	4	-	1	5	6
Maine	2	1	11	21	5	5	-	-	-	-	-	-
N.H.	6	12	16	18	14	16	-	-	-	-	-	3
Vt.	3	9	16	10	4	6	-	1	-	-	1	3
Mass.	40	38	260	128	11	14	-	2	-	1	3	-
R.I.	5	4	59	23	25	21	-	-	-	-	-	-
Conn.	30	33	220	160	31	39	-	1	-	-	1	-
MID. ATLANTIC	174	215	865	1,393	909	1,060	-	5	-	11	16	21
Upstate N.Y.	68	93	244	231	121	121	-	1	-	4	5	10
N.Y. City	44	58	275	475	392	516	-	3	-	1	4	10
N.J.	42	38	159	263	169	163	-	-	-	1	1	-
Pa.	20	26	187	424	227	260	-	1	-	5	6	1
E.N. CENTRAL	176	163	1,056	1,533	830	662	-	-	-	10	10	8
Ohio	55	49	208	244	84	97	-	-	-	3	3	2
Ind.	46	28	95	110	47	45	-	-	-	4	4	-
Ill.	40	56	385	651	149	108	-	-	-	3	3	3
Mich.	13	9	301	451	550	374	-	-	-	-	-	3
Wis.	22	21	67	77	-	38	-	-	-	-	-	-
W.N. CENTRAL	60	72	380	617	189	267	-	4	-	1	5	2
Minn.	37	42	40	169	21	35	-	2	-	1	3	1
Iowa	-	-	36	62	25	31	-	-	-	-	-	-
Mo.	14	20	103	247	103	130	-	2	-	-	2	-
N. Dak.	7	2	3	3	1	2	-	-	-	-	-	-
S. Dak.	-	1	3	2	1	1	-	-	-	-	-	-
Nebr.	1	3	31	31	22	42	-	-	-	-	-	-
Kans.	1	4	164	103	16	26	-	-	-	-	-	1
S. ATLANTIC	343	254	2,154	1,329	1,354	1,166	-	4	-	1	5	4
Del.	-	-	-	15	-	14	-	-	-	-	-	-
Md.	83	75	269	185	130	113	-	2	-	1	3	-
D.C.	-	-	51	24	11	29	-	-	-	-	-	-
Va.	27	37	122	146	163	152	-	1	-	-	1	2
W. Va.	14	8	25	53	20	15	-	-	-	-	-	-
N.C.	44	23	206	129	199	226	-	-	-	-	-	-
S.C.	7	7	70	76	29	21	-	-	-	-	-	-
Ga.	95	63	859	279	442	218	-	1	-	-	1	-
Fla.	73	41	552	422	360	378	-	-	-	-	-	2
E.S. CENTRAL	68	46	361	367	385	428	-	2	-	-	2	-
Ky.	2	12	119	47	40	69	-	2	-	-	2	-
Tenn.	38	20	144	131	212	202	-	-	-	-	-	-
Ala.	26	12	71	48	79	57	-	-	-	-	-	-
Miss.	2	2	27	141	54	100	U	-	U	-	-	-
W.S. CENTRAL	47	62	1,189	2,222	652	1,014	-	-	-	1	1	-
Ark.	1	2	63	126	91	90	-	-	-	-	-	-
La.	6	16	57	89	44	143	-	-	-	-	-	-
Okla.	39	42	111	241	106	147	-	-	-	-	-	-
Tex.	1	2	958	1,766	411	634	-	-	-	1	1	-
MOUNTAIN	127	123	670	853	450	484	-	1	-	1	2	12
Mont.	-	1	11	7	3	6	-	-	-	-	-	-
Idaho	2	4	54	30	11	6	-	-	-	1	1	-
Wyo.	-	1	7	4	3	3	-	-	-	-	-	-
Colo.	34	31	85	194	104	94	-	-	-	-	-	2
N. Mex.	20	24	37	68	128	127	-	-	-	-	-	-
Ariz.	54	45	353	418	132	177	-	1	-	-	1	-
Utah	7	11	69	57	26	24	-	-	-	-	-	3
Nev.	10	6	55	75	43	47	-	-	-	-	-	7
PACIFIC	97	143	1,787	3,189	1,034	1,191	-	31	-	18	49	22
Wash.	5	7	141	262	131	105	-	13	-	2	15	3
Oreg.	19	32	68	159	105	110	-	4	-	-	4	-
Calif.	44	35	1,561	2,742	772	953	-	12	-	11	23	15
Alaska	6	45	14	13	9	11	-	-	-	-	-	1
Hawaii	23	24	3	13	17	12	-	2	-	5	7	3
Guam	-	1	-	1	-	10	U	-	U	-	-	-
P.R.	1	4	119	233	176	260	-	-	-	-	-	2
V.I.	-	-	-	-	-	-	U	-	U	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	35	U	-	-	-	-	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.

* Incidence data for reporting year 2001 are provisional and cumulative (year-to-date). Incidence data for reporting year 2000 are finalized and cumulative (year-to-date).

† For imported measles, cases include only those resulting from importation from other countries.

§ Of 251 cases among children aged <5 years, serotype was reported for 120, and of those, 20 were type b.

TABLE III. (Cont'd) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending November 24, 2001, and November 25, 2000 (47th Week)*

Reporting Area	Meningococcal Disease		Mumps			Pertussis			Rubella		
	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000
UNITED STATES	1,963	1,968	2	197	293	50	4,247	6,435	-	21	165
NEW ENGLAND	101	117	-	-	4	1	393	1,715	-	-	12
Maine	4	8	-	-	-	-	21	45	-	-	-
N.H.	13	12	-	-	-	-	38	117	-	-	2
Vt.	6	3	-	-	-	1	31	229	-	-	-
Mass.	52	67	-	-	1	-	281	1,260	-	-	8
R.I.	4	9	-	-	1	-	5	19	-	-	1
Conn.	22	18	-	-	2	-	17	45	-	-	1
MID. ATLANTIC	197	231	-	20	26	1	263	643	-	5	9
Upstate N.Y.	57	69	-	3	10	1	131	320	-	1	1
N.Y. City	39	40	-	10	7	-	44	82	-	3	8
N.J.	46	47	-	3	3	-	18	30	-	1	-
Pa.	55	75	-	4	6	-	70	211	-	-	-
E.N. CENTRAL	251	357	-	19	22	3	594	756	-	3	1
Ohio	69	84	-	1	7	3	231	309	-	-	-
Ind.	36	41	-	3	1	-	79	107	-	1	-
Ill.	44	81	-	11	6	-	68	111	-	2	1
Mich.	60	109	-	4	6	-	129	110	-	-	-
Wis.	42	42	-	-	2	-	87	119	-	-	-
W.N. CENTRAL	138	140	2	10	17	3	312	548	-	3	2
Minn.	20	21	-	3	-	-	146	331	-	-	1
Iowa	28	32	-	-	7	-	33	53	-	1	-
Mo.	48	63	1	2	4	-	92	84	-	1	-
N. Dak.	6	2	-	-	1	1	5	6	-	-	-
S. Dak.	5	5	-	-	-	-	4	7	-	-	-
Nebr.	17	7	-	1	2	2	6	27	-	-	1
Kans.	14	10	1	4	3	-	26	40	-	1	-
S. ATLANTIC	342	262	-	37	43	1	238	467	-	7	112
Del.	4	1	-	-	-	-	-	8	-	1	1
Md.	38	26	-	7	9	-	38	113	-	-	-
D.C.	-	-	-	-	-	-	1	3	-	-	-
Va.	37	38	-	8	10	-	41	106	-	-	-
W. Va.	13	13	-	-	-	1	4	1	-	-	-
N.C.	62	36	-	5	7	-	69	108	-	-	82
S.C.	34	21	-	5	11	-	32	31	-	2	27
Ga.	47	44	-	7	2	-	27	38	-	1	-
Fla.	107	83	-	5	4	-	26	59	-	3	2
E.S. CENTRAL	123	127	-	9	5	-	139	108	-	-	6
Ky.	21	26	-	3	1	-	43	55	-	-	1
Tenn.	56	53	-	1	2	-	57	32	-	-	1
Ala.	31	34	-	-	2	-	36	18	-	-	4
Miss.	15	14	U	5	-	U	4	3	U	-	-
W.S. CENTRAL	316	207	-	13	32	2	448	348	-	1	8
Ark.	18	12	-	1	3	-	44	35	-	-	1
La.	61	43	-	2	5	-	2	19	-	-	1
Okla.	28	26	-	-	-	-	27	47	-	-	-
Tex.	209	126	-	10	24	2	375	247	-	1	6
MOUNTAIN	85	93	-	11	19	21	1,214	729	-	1	2
Mont.	4	4	-	1	1	-	37	35	-	-	-
Idaho	7	7	-	1	-	-	170	59	-	-	-
Wyo.	5	1	-	1	1	-	1	4	-	-	-
Colo.	31	32	-	1	-	8	261	434	-	1	1
N. Mex.	10	10	-	2	1	-	135	85	-	-	-
Ariz.	13	29	-	1	4	11	509	73	-	-	1
Utah	8	7	-	1	6	1	76	24	-	-	-
Nev.	7	3	-	3	6	1	25	15	-	-	-
PACIFIC	410	434	-	78	125	18	646	1,121	-	1	13
Wash.	60	53	-	2	9	17	159	391	-	-	7
Oreg.	40	64	N	N	N	-	50	106	-	-	-
Calif.	295	301	-	39	87	-	395	564	-	-	6
Alaska	2	8	-	1	8	1	11	21	-	-	-
Hawaii	13	8	-	36	21	-	31	39	-	1	-
Guam	-	-	U	-	16	U	-	4	U	-	1
P.R.	4	9	-	-	-	-	2	9	-	-	-
V.I.	-	-	U	-	-	U	-	-	U	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	-	U	-	-	U	-	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.

* Incidence data for reporting year 2001 are provisional and cumulative (year-to-date). Incidence data for reporting year 2000 are finalized and cumulative (year-to-date).

TABLE IV. Deaths in 122 U.S. cities,* week ending November 24, 2001 (47th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	470	339	79	39	9	4	47
Boston, Mass.	126	79	30	12	5	-	13
Bridgeport, Conn.	23	18	2	1	-	2	1
Cambridge, Mass.	16	14	1	1	-	-	-
Fall River, Mass.	18	17	-	1	-	-	2
Hartford, Conn.	U	U	U	U	U	U	U
Lowell, Mass.	28	21	7	-	-	-	4
Lynn, Mass.	11	8	-	3	-	-	-
New Bedford, Mass.	20	15	3	2	-	-	3
New Haven, Conn.	30	21	8	1	-	-	3
Providence, R.I.	57	43	8	6	-	-	-
Somerville, Mass.	3	2	1	-	-	-	-
Springfield, Mass.	48	30	7	6	3	2	5
Waterbury, Conn.	35	30	4	1	-	-	7
Worcester, Mass.	55	41	8	5	1	-	9
MID. ATLANTIC	1,928	1,306	373	185	32	30	89
Albany, N.Y.	53	36	11	3	1	2	5
Allentown, Pa.	18	15	2	1	-	-	-
Buffalo, N.Y.	102	82	15	2	1	2	5
Camden, N.J.	25	16	3	4	-	2	1
Elizabeth, N.J.	10	8	1	1	-	-	-
Erie, Pa.§	40	33	4	2	1	-	2
Jersey City, N.J.	39	26	6	3	2	2	-
New York City, N.Y.	1,085	699	216	135	20	14	43
Newark, N.J.	U	U	U	U	U	U	U
Paterson, N.J.	15	8	3	4	-	-	1
Philadelphia, Pa.	252	155	65	19	6	6	12
Pittsburgh, Pa.§	30	19	8	2	-	1	2
Reading, Pa.	18	14	4	-	-	-	1
Rochester, N.Y.	86	71	12	2	-	1	4
Schenectady, N.Y.	11	9	2	-	-	-	1
Scranton, Pa.§	26	18	7	1	-	-	-
Syracuse, N.Y.	82	67	11	3	1	-	11
Trenton, N.J.	16	12	2	2	-	-	1
Utica, N.Y.	20	18	1	1	-	-	-
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	1,231	872	261	60	18	20	76
Akron, Ohio	23	17	5	-	-	1	2
Canton, Ohio	35	26	8	1	-	-	3
Chicago, Ill.	U	U	U	U	U	U	U
Cincinnati, Ohio	52	38	12	2	-	2	7
Cleveland, Ohio	140	93	34	8	4	1	3
Columbus, Ohio	160	106	42	7	2	3	5
Dayton, Ohio	92	66	17	6	1	2	5
Detroit, Mich.	112	56	38	14	3	2	4
Evansville, Ind.	29	19	9	-	1	-	1
Fort Wayne, Ind.	35	27	5	1	2	-	2
Gary, Ind.	15	11	3	-	1	-	-
Grand Rapids, Mich.	38	30	5	-	1	2	9
Indianapolis, Ind.	165	125	25	11	-	4	12
Lansing, Mich.	32	25	5	-	2	-	4
Milwaukee, Wis.	83	67	14	2	-	-	5
Peoria, Ill.	29	21	7	-	1	-	1
Rockford, Ill.	38	29	8	1	-	-	3
South Bend, Ind.	39	32	6	1	-	-	4
Toledo, Ohio	71	51	13	4	-	3	6
Youngstown, Ohio	43	36	5	2	-	-	-
W.N. CENTRAL	521	374	97	27	13	10	42
Des Moines, Iowa	71	54	13	3	-	1	10
Duluth, Minn.	10	7	2	1	-	-	1
Kansas City, Kans.	U	U	U	U	U	U	U
Kansas City, Mo.	80	54	17	5	3	1	5
Lincoln, Nebr.	47	37	9	1	-	-	2
Minneapolis, Minn.	110	75	19	11	2	3	12
Omaha, Nebr.	68	49	14	2	1	2	9
St. Louis, Mo.	67	40	15	3	7	2	2
St. Paul, Minn.	68	58	8	1	-	1	1
Wichita, Kans.	U	U	U	U	U	U	U
S. ATLANTIC	957	595	222	78	33	27	58
Atlanta, Ga.	126	66	41	12	3	4	1
Baltimore, Md.	232	132	51	26	15	7	19
Charlotte, N.C.	73	52	12	6	2	-	12
Jacksonville, Fla.	80	57	15	6	1	1	7
Miami, Fla.	U	U	U	U	U	U	U
Norfolk, Va.	50	31	11	4	2	2	1
Richmond, Va.	48	29	14	2	1	2	2
Savannah, Ga.	44	29	12	-	1	2	2
St. Petersburg, Fla.	40	34	5	1	-	-	4
Tampa, Fla.	148	103	29	7	4	5	8
Washington, D.C.	100	53	25	14	4	4	2
Wilmington, Del.	16	9	7	-	-	-	-
E.S. CENTRAL	495	321	121	29	15	8	35
Birmingham, Ala.	143	92	36	9	3	2	9
Chattanooga, Tenn.	59	46	10	1	2	-	5
Knoxville, Tenn.	45	29	12	3	1	-	5
Lexington, Ky.	33	23	8	2	-	-	3
Memphis, Tenn.	183	112	46	12	7	6	11
Mobile, Ala.	16	6	6	2	2	-	2
Montgomery, Ala.	16	13	3	-	-	-	-
Nashville, Tenn.	U	U	U	U	U	U	U
W.S. CENTRAL	904	541	177	93	70	23	39
Austin, Tex.	63	39	12	11	1	-	2
Baton Rouge, La.	2	-	1	1	-	-	-
Corpus Christi, Tex.	23	16	5	2	-	-	-
Dallas, Tex.	117	75	23	10	7	2	8
El Paso, Tex.	32	25	5	-	1	1	2
Ft. Worth, Tex.	90	59	24	5	-	2	4
Houston, Tex.	322	156	58	43	54	11	9
Little Rock, Ark.	42	26	13	2	-	1	1
New Orleans, La.	U	U	U	U	U	U	U
San Antonio, Tex.	124	84	21	9	5	5	6
Shreveport, La.	U	U	U	U	U	U	U
Tulsa, Okla.	89	61	15	10	2	1	7
MOUNTAIN	827	558	160	58	32	16	49
Albuquerque, N.M.	71	48	12	7	4	-	2
Boise, Idaho	31	26	3	1	1	-	4
Colo. Springs, Colo.	60	45	8	5	2	-	4
Denver, Colo.	102	63	21	9	4	5	8
Las Vegas, Nev.	157	104	38	9	3	3	8
Ogden, Utah	18	15	2	1	-	-	-
Phoenix, Ariz.	142	78	36	13	7	5	8
Pueblo, Colo.	30	21	6	1	2	-	1
Salt Lake City, Utah	86	61	13	5	5	2	6
Tucson, Ariz.	130	97	21	7	4	1	8
PACIFIC	963	650	175	79	31	28	76
Berkeley, Calif.	8	4	3	-	-	1	1
Fresno, Calif.	93	55	18	15	5	-	5
Glendale, Calif.	6	5	-	1	-	-	-
Honolulu, Hawaii	56	44	7	3	1	1	5
Long Beach, Calif.	71	50	11	4	4	2	11
Los Angeles, Calif.	124	70	30	17	4	3	3
Pasadena, Calif.	23	17	5	1	-	-	7
Portland, Oreg.	92	60	16	10	2	4	4
Sacramento, Calif.	U	U	U	U	U	U	U
San Diego, Calif.	136	95	25	9	4	3	13
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	122	89	17	6	2	8	9
Santa Cruz, Calif.	18	13	1	3	1	-	3
Seattle, Wash.	86	60	14	5	3	4	7
Spokane, Wash.	49	34	12	-	2	-	4
Tacoma, Wash.	80	54	16	5	3	2	4
TOTAL	8,296	¶5,556	1,665	648	253	166	511

U: Unavailable. -:No reported cases.

* Mortality data in this table are reported voluntarily from 122 cities in the United States, most of which have populations of ≥100,000. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

† Pneumonia and influenza.

§ Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶ Total includes unknown ages.

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